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## Obamacare, Medicare, and Baseball's Greatest Pitchers

Jonathan Cohn\*

What follows is a story about health policy and baseball—and how the latter can help us to understand the former.

The primary subject of debate in health policy these days is about the Affordable Care Act (ACA)—or, as it's come to be known, "Obamacare." Mostly it has been a debate between those who, broadly speaking, support the idea of a universal health insurance system and those who do not. But even among those of us who support universal coverage, the ACA generates decidedly mixed feelings.

When we feel good about the ACA, we can point to data showing that it is achieving its primary goals. Surveys indicate that the number of people without health insurance has declined substantially—by somewhere between eight and fourteen million, depending on which numbers we want to believe. Then there is the evidence that people are getting more health care and that, as a result, they are better off physically, financially, or both. Health care costs—for employers, for governments, and ultimately for the country as a whole—are rising at historically low rates. New research even suggests that the incidence of hazardous medical errors is falling. The ACA is not responsible for all of this progress, but it explains a great deal. That makes many of us happy.<sup>1</sup>

But we also know that the ACA has some big shortcomings, too. Tens of millions of people will remain uninsured, even after the law has fully phased in. Some of these people will be undocumented workers. Some will not. All will lack health insurance, putting them at risk of financial catastrophe and adding strain to the safety net. Even those who have insurance will find their coverage leaves them exposed to high out-of-pocket costs—lower than before, perhaps, but still high enough to cause hardship. A paper co-authored by MIT economist Jonathan Gruber—as fierce an ACA defender as you will find—concluded that about 10% of families would not have enough money for premiums and out-of-pocket expenses if they got severely ill.<sup>2</sup>

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\* Jonathan Cohn is a Senior National Correspondent for the Huffington Post.

1. David Blumenthal & Sara Collins, *Assessing the Affordable Care Act: The Record to Date*, COMMONWEALTH FUND (Sept. 2014), <http://www.commonwealthfund.org/publications/blog/2014/sep/assessing-the-affordable-care-act>.

2. Jonathan Gruber & Ian Perry, *Will the Affordable Care Act Make Insurance Affordable?*, COMMONWEALTH FUND (Apr. 2011), [http://www.commonwealthfund.org/~media/files/publications/issue-brief/2011/apr/1493\\_gruber\\_will\\_affordable\\_care\\_act\\_make\\_hlt\\_ins\\_affordable\\_reform\\_brief\\_com](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2011/apr/1493_gruber_will_affordable_care_act_make_hlt_ins_affordable_reform_brief_com)

The deals necessary to enact the law have been well documented. Many industries, particularly the drug industry, seem to have gotten off awfully light. And those industries that took harder hits—like the device industry—may yet get Congress to roll back cuts or taxes that affect them. Meanwhile, the law relies heavily on regulators who might not be up to the task—whether it is at the state level, particularly in some more conservative states, or even at the federal level, where an Administration so nervous about high premiums has been reluctant to deploy the authority that the law theoretically allows. One case of this is the problems with “narrow networks” and balance billing. As Elisabeth Rosenthal of the *New York Times* has documented, newly insured people have been showing up at emergency rooms and unexpectedly getting huge bills afterwards, because their hospitals were in network but the physicians were not.<sup>3</sup>

And, of course, the law is just very confusing. Health care is complicated; any reform was bound to require intricate legislation and yet more intricate regulation. But from an operational standpoint—from the standpoint of a consumer trying to get and use an insurance policy, or a small business owner trying to buy coverage for employees—it is a mess.

What makes this all particularly upsetting is that we know it is possible to do better. Need proof? Just consider the program that celebrates its 50<sup>th</sup> anniversary in 2014: Medicare.

Medicare is truly universal coverage and it was that way from the get-go. By 1970, 97% of senior citizens had health insurance through the program.<sup>4</sup> From the beneficiary’s standpoint, Medicare is also easy to use. The program has no physician or hospital networks, for example. You can see any doctor who will accept it, which in practice has meant nearly all doctors—despite rumors that physicians are fleeing the program. And Medicare has historically done a good job of controlling costs, arguably a little better than the private sector, by using its leverage with doctors and hospitals to set prices.<sup>5</sup>

So if given a chance to have a program like Medicare—Medicare for all—rather than the Affordable Care Act, would most of us have jumped at it? Probably. And this is likely one reason the Affordable Care Act has less than a stellar

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3. Elisabeth Rosenthal, *Costs Can Go Up Fast in ER When Hospital Is In Network But the Doctors Are Not*, N.Y. TIMES, Sept. 29, 2014, <http://www.nytimes.com/2014/09/29/us/costs-can-go-up-fast-when-er-is-in-network-but-the-doctors-are-not.html>.

4. Marilyn Moon, *What Medicare Has Meant to Older Americans*, 18 HEALTH CARE FIN. REV. (Winter 1996), <http://www.ssa.gov/history/pdf/WhatMedicareMeant.pdf>.

5. *Per Enrollee Growth in Medicare Spending and Private Health Insurance for Common Benefits, 1970-2012*, KAISER FAM. FOUND. (Mar. 2014), <http://kff.org/health-costs/slide/per-enrollee-growth-in-medicare-spending-and-private-health-insurance-premiums-for-common-benefits-1970-2012/>.

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reputation, even among advocates.

But maybe, just maybe, we should stop and think. We are comparing Medicare, which became law in 1965, to the Affordable Care Act, which became law in 2010. Is that fair?

Here is where a little knowledge about baseball can help us.

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In 1999, the best pitcher in baseball played for the Boston Red Sox. His name was Pedro Martinez and he was the kind of pitcher who could shut down the very best hitters in the game. He proved this memorably during the 1999 All-Star Game, which happened to be at Fenway Park, and during which he struck out five of the first six batters in the National League lineup. Pedro finished the season with an astonishingly low Earned Run Average (ERA) of 2.07. People said it was the best pitching season of the modern era.

Fifteen years later, in 2014, the best pitcher in baseball was Clayton Kershaw, of the Los Angeles Dodgers. He performed some similarly unfathomable feats, including a no-hitter in which he struck out fifteen batters. Kershaw, like Pedro, could strike out the best hitters in the game. And by the time the season was over, Kershaw was sitting on an ERA of 1.77—yes, even lower than Pedro's Herculean achievement from 1999. Afterwards, many people concluded that it was Kershaw, not Pedro, who had posted the best season of the modern era.

At first blush, the revision made sense. But was the comparison really fair? Consider that Kershaw pitched in the National League, while Pedro was in the American, which uses the Designated Hitter. Every lineup Pedro faced had nine serious batters, not eight plus a weak-hitting pitcher.

Kershaw pitched at Dodger Stadium, with far-off, equidistant homerun fences and lots of foul ground for catching pop-ups. Pedro pitched in Fenway Park, a century-old stadium with almost no foul ground and a close-in left field fence, the Green Monster, which famously turned routine fly-outs into singles. Note, too, that Kershaw pitched after the league had introduced widespread steroid testing, dramatically reducing the use of performance enhancing drugs. Pedro had pitched at the peak of the steroid era. As *The Atlantic's* Derek Thompson has observed, in his own comparison of the two seasons, Pedro's historic success against such drug-boosted competition "is kind of like somebody breaking the Boston Marathon record in the middle of a snowstorm."<sup>6</sup>

Most important of all, baseball in 2001 began introducing computer monitors to track pitches and display the strike zone. The results caught everybody's

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6. Derek Thompson, *Did Clayton Kershaw Just Have the Greatest Season in Baseball History?*, THE ATLANTIC, Sept. 26, 2014, [http://www.theatlantic.com/entertainment/archive/2014/09/did-clayton-kershaw-just-have-the-best-summer-in-baseball-history/380812/?single\\_page=true](http://www.theatlantic.com/entertainment/archive/2014/09/did-clayton-kershaw-just-have-the-best-summer-in-baseball-history/380812/?single_page=true)

attention: Umpires had been routinely narrowing the strike zone, so that pitches at a batter's knees—a strike, according to the rule book—would be a ball. Chastened by the computer data, and subsequently held to new league-wide performance standards, umpires began changing their behavior, as the University of Florida sports economist Brian Mills has documented.<sup>7</sup> The ultimate effect was to expand the strike zone between 2008 and 2014 from 436 square inches to 475 square inches.<sup>8</sup> That is a lot larger, and makes it a lot easier on pitchers.

In a straightforward comparison of the numbers, Kershaw's season was better. But given the circumstances—specifically, changes in the playing environment, the level of competition, the rules of the game—Pedro had performed just as well, maybe even better.<sup>9</sup> To judge his season without taking account of this context would be unfair.

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And so it is with our comparisons of Medicare to Obamacare.

Health care was a very different enterprise back in the 1960s. For one thing, it was much, much less expensive. Medicare's architects didn't have to worry so much about what the plan might cost, because overall health care spending was still pretty modest (around 6% of GDP) as was public debt (around 40% of GDP). By 2010, when President Obama and his allies were trying to construct legislation, health care spending was more than 15% of GDP and the public debt was approaching 90% of GDP.<sup>10</sup>

Those numbers imposed constraints, real and imagined, on what the designers of Obamacare could accomplish. They had to devise a program that could to pay for itself—or come pretty darn close—and they had to at least attempt to control underlying health care costs, both for the sake of stabilizing the federal budget and offering relief to individuals and businesses paying for insurance and out of pocket

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7. Brian M. Mills, *Expert Workers, Performance Standards, and On-the-Job Training: Evaluating Major League Umpires*, SSRN WORKING PAPERS SERIES (Aug. 27, 2014), [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=2478447](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2478447).

8. Joe Roegel, *The Strike Zone Expansion Is Out of Control*, *HARDBALL TIMES*, Oct. 13, 2014, <http://www.hardballtimes.com/the-strike-zone-expansion-is-out-of-control/>.

9. Pedro's "seasonally adjusted ERA" for 1999 was 291, the second-best ever, behind only Tim Lincecum, who pitched for the Troy Trojans in 1880. Kershaw's seasonally adjusted ERA for 2014 was 197—which, though still very impressive, merely ties for 39th on the all-time list. The statistics are available at the online site. See *BASEBALL-REFERENCE.COM.*, [http://www.baseball-reference.com/leaders/earned\\_run\\_avg\\_plus\\_season.shtml](http://www.baseball-reference.com/leaders/earned_run_avg_plus_season.shtml) (last visited Jan. 2, 2014).

10. See *FEDERAL RESERVE BANK OF ST. LOUIS*, <http://research.stlouisfed.org/fred2/series/GFDEGDQ188S> (last visited Jan. 2, 2014); *National Health Expenditure Accounts*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html> (last visited Jan. 2, 2014).

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expenses.

The political environment was different too. Back in the 1960s, the majority of Americans believed that government usually did the right thing—and raising taxes, although never popular, were understood to be a routine part of government. By the time Obama became president, faith in government had plummeted and calls to taxes, except on the very rich, were politically toxic.<sup>11</sup>

The 1960s had their political divisions, particularly later in the decade, but at the time Medicare became law there was still something that could be called a political establishment—and, along with it, a business establishment—that counted both liberals and conservatives as members in good standing. That kind of establishment does not exist today, in Congress or in the business community. Or in the media, for that matter—online and on cable news, partisan media now drive the conversation, amplifying fringe voices and sensationalizing news of the extreme.<sup>12</sup>

Can you imagine trying to pass Medicare today, in this environment, let alone implementing it? Senator Joe Lieberman, the conservative Democrat from Connecticut who gave Obama and Democratic leaders fits in 2009 and 2010, would have insisted the program be run through private insurance companies—carrying water for the hospital and drug industries and speaking for a whole bunch of senators (even liberal ones) who did not want public programs setting prices. Senator Ben Nelson, another conservative Democrat, would have held up the whole thing until the architects agreed to raise reimbursements for his home state of Nebraska.

Former Alaska Governor Sarah Palin, spokesperson of the far right, would have insisted Medicare was actually going to impose death panels—and Fox News, leader of the conservative media, would have interviewed every single person who had good insurance previously, even though there were not very many, and run stories bemoaning the fact they would have to switch to that terrible new government program.

That is not to say that passing or implementing Medicare was easy. Nobody who has read the histories written by Ted Marmor, Jonathan Oberlander, and other scholars could say such a thing.<sup>13</sup> But the obstacles to what became the Affordable Care Act were arguably even greater—which meant that, in order to pass

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11. *Public Trust in Government, 1958-2014*, PEW RESEARCH CENTER FOR THE PEOPLE AND THE PRESS (Nov. 13, 2014), <http://www.people-press.org/2014/11/13/public-trust-in-government/>.

12. For a discussion of the changing American establishment, see JOHN B. JUDIS, *THE PARADOX OF AMERICAN DEMOCRACY: ELITES, SPECIAL INTERESTS, AND THE BETRAYAL OF PUBLIC TRUST* (1991).

13. See THEODORE MARMOR, *THE POLITICS OF MEDICARE*, 2ND EDITION (2000); JONATHAN OBERLANDER, *THE POLITICAL LIFE OF MEDICARE* (2003).

legislation, the architects had to make sacrifices that Medicare's architects did not.

Sometimes these compromises actually worked out for the better. The determination to reduce the cost of medicine, for example, has led to changes like penalties for hospitals with high rates of readmission. Those penalties may be one reason that medical errors and failures of follow-up care are becoming more frequent. But frequently the compromises meant that the ACA did less—or accomplished a key goal like expanding insurance coverage in a less effective way.

There is nothing wrong with comparing the ACA and Medicare. But you cannot truly measure an accomplishment without taking account of the obstacles overcome along the way. Just ask Barack Obama. Or Pedro Martinez.